LAW OFFICES
SHAEVITZ & SHAEVITZ
148-55 HILLSIDE AVENUE
JAMAICA, NEW YORK, 11435

OLIVER SHAEVITZ
MARK A. SHAEVITZ
ERIC G. SHAEVITZ

JON F. EPSTEIN
STUART L. SEARS
DIMITRI KOTZAMANIS
JONATHAN R. VITARELLI

TELEPHONE
(718) 291-3400

FAX
(718) 739-5654

OF COUNSEL
MICHAEL J. BUTLER
NORMA GIFFORDS

LoERN M. MILLER
OFFICE MANAGER

January 5, 2009

Circuit City Stores, Inc., et. al.
Claims Processing Dept.
c/o Kurtzman Carson Consultants LLC
2335 Alaska Avenue
El Segundo, CA 90245

Re: Client: ANNA THOMAS
Chapter 11
Case Number: 08-35653
Debtor: Circuit City Stores, Inc.

Dear Sir/Madam:

Enclosed please find ANNA THOMAS' Proof of Claim relating to the above mentioned claim.

Additionally, please find the following documents substantiating said Proof of Claim:

Exhibit A - A copy of claimant's Summons and Complaint;
Exhibit B - A copy of the Answer from debtor;
Exhibit C - A copy of claimant's Bill of Particulars;
Exhibit D - Copies of claimant's medical records relating to the herein claim.

If you should require additional information, please contact the undersigned.

Very truly yours,

STUART SEARS

SS/cp
Enc.

7007 1490 0004 9270 0790

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com

OFFICIAL USE

Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
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Postmark Here
01/07/09

Sent To
Circuit City Stores, Inc. - Claims Process Dept.
Street, Apt. No.; or PO Box
c/o Kurtzman Carson Consultants
City, State, ZIP+4
2335 Alaska Ave - El Segundo CA 90245

PS Form 3800, August 2006 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Circuit City Stores, Inc
Claims Processing Dept.
c/o Kurtzman Carson Consultants, LLC
2335 Alaska Avenue
El Segundo, CA 90245

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addre

B. Received by (Printed Name) C. Date of Deli

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchand
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7007 1490 0004 9270 0790

The Debtor has listed your claim as Contingent, Unliquidated, and Disputed on Schedule F as a General Unsecured claim. If you believe that you have a claim against the Debtor, you are required to complete and return this form.

B 10 (Official Form 10) (12/07)

UNITED STATES BANKRUPTCY COURT FOR THE EASTERN DISTRICT OF VIRGINIA	PROOF OF CLAIM

Debtor against which claim is asserted : (Check only one box below:)

X Circuit City Stores, Inc. (Case No. 08-35653)	CC Distribution Company of Virginia, Inc. (Case No. 08-35659)	Abbott Advertising, Inc. (Case No. 08-35665)
Circuit City Stores West Coast, Inc. (Case No. 08-35654)	Circuit City Stores PR, LLC (Case No. 08-35660)	Mayland MN, LLC (Case No. 08-35666)
InterTAN, Inc. (Case No. 08-35655)	Circuit City Properties, LLC (Case No. 08-35661)	Patapsco Designs, Inc. (Case No. 08-35667)
Ventoux International, Inc. (Case No. 08-35656)	Orbyx Electronics, LLC (Case No. 08-35662)	Sky Venture Corporation (Case No. 08-35668)
Circuit City Purchasing Company, LLC (Case No. 08-35657)	Kinzer Technology, LLC (Case No. 08-35663)	XSStuff, LLC (Case No. 08-35669)
CC Aviation, LLC (Case No. 08-35658)	Courchevel, LLC (Case No. 08-35664)	PRAHS, INC. (Case No. 08-35670)

Name of Creditor (the person or other entity to whom the debtor owes money or property):

THOMAS, ANNA

Name and address where notices should be sent:

NameID: 4989881 **PackID: 433075**

THOMAS, ANNA
99 10 60TH AVE
APT 5J
CORONA NY 11368

Telephone number:

☐ Check this box to indicate that this claim amends a previously filed claim.

Court Claim Number:_____
(If known)

Filed on:_____

Name and address where payment should be sent (if different from above):

Shaeritz & Shaeritz
148-55 Hillside Avenue
Jamaica, New York 11435

Telephone number: (718) 291-3400

☐ Check this box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.

☐ Check this box if you are the debtor or trustee in this case.

1. Amount of Claim as of Date Case Filed: $ 1,000,000.00

If all or part of your claim is secured, complete item 4 below; however, if all of your claim is unsecured, do not complete item 4.

If all or part of your claim is entitled to priority, complete item 5.

☐ Check this box if claim includes interest or other charges in addition to the principal amount of claim. Attach itemized statement of interest or charges.

2. Basis for Claim: Personal Injury
(See instruction #2 on reverse side.)

3. Last four digits of any number by which creditor identifies debtor:_____

3a. Debtor may have scheduled account as:_____
(See instruction #3a on reverse side.)

4. Secured Claim (See instruction #4 on reverse side.)
Check the appropriate box if your claim is secured by a lien on property or a right of setoff and provide the requested information.

Nature of property or right of setoff: Real Estate Motor Vehicle Other
Describe:

Value of Property: $_____ **Annual Interest Rate** ___%

Amount of arrearage and other charges as of time case filed included in secured claim, if any: $_____ **Basis for perfection:**_____

Amount of Secured Claim: $_____ **Amount Unsecured: $**_____

5. Amount of Claim Entitled to Priority under 11 U.S.C. § 507(a). If any portion of your claim falls in one of the following categories, check the box and state the amount.

Specify the priority of the claim.

☐ Domestic support obligations under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).

☐ Wages, salaries, or commissions (up to $10,950*) earned within 180 days before filing of the bankruptcy petition or cessation of the debtors business, whichever is earlier — 11 U.S.C. § 507(a)(4).

☐ Contributions to an employee benefit plan — 11 U.S.C. § 507(a)(5).

☐ Up to $2,425* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use — 11 U.S.C. § 507(a)(7).

☐ Taxes or penalties owed to governmental units — 11 U.S.C. § 507(a)(8).

☐ Other - Specify applicable paragraph of 11 U.S.C. § 507(a)(___).

Amount entitled to priority:

$_____

**Amounts are subject to adjustment on 4/1/10 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment*

6. Credits: The amount of all payments on this claim has been credited for the purpose of making this proof of claim.

7. Documents: Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements or running accounts, contracts, judgments, mortgages, and security agreements. You may also attach a summary. Attach redacted copies of documents providing evidence of perfection of a security interest. You may also attach a summary. *(See definition of "redacted" on reverse side.)*

DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.

If the documents are not available, please explain:

Date: 12-29-08

Signature: the person filing this claim must sign it. Sign and print name and title, if any, of the creditor or other person authorized to file this claim and state address and telephone number if different from the notice address above. Attach copy of power of attorney, if any.

Anna Thomas

FOR COURT USE ONLY

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

MasterCode: 10018074

08356530812180741177163

B 10 (Official Form 10) (12/07)- Cont.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The instructions and definitions below are general explanations of the law. In certain circumstances, such as bankruptcy cases not filed voluntarily by the debtor, there may be exceptions to these general rules.

Items to be completed in Proof of Claim form

Court, Name of Debtor, and Case Number:
Fill in the federal judicial district where the bankruptcy case was filed (for example, Central District of California), the bankruptcy debtor's name, and the bankruptcy case number. If the creditor received a notice of the case from the bankruptcy court, all of this information is located at the top of the notice.

Creditor's Name and Address:
Fill in the name of the person or entity asserting a claim and the name and address of the person who should receive notices issued during the bankruptcy case. A separate space is provided for the payment address if it differs from the notice address. The creditor has a continuing obligation to keep the court informed of its current address. See Federal Rule of Bankruptcy Procedure (FRBP) 2002(g).

1. **Amount of Claim as of Date Case Filed:**
State the total amount owed to the creditor on the date of the Bankruptcy filing. Follow the instructions concerning whether to complete items 4 and 5. Check the box if interest or other charges are included in the claim.

2. **Basis for Claim:**
State the type of debt or how it was incurred. Examples include goods sold, money loaned, services performed, personal injury/wrongful death, car loan, mortgage note, and credit card.

3. **Last Four Digits of Any Number by Which Creditor Identifies Debtor:**
State only the last four digits of the debtor's account or other number used by the creditor to identify the debtor.

3a. Debtor May Have Scheduled Account As:
Use this space to report a change in the creditor's name, a transferred claim, or any other information that clarifies a difference between this proof of claim and the claim as scheduled by the debtor.

4. **Secured Claim.**
Check the appropriate box and provide the requested information if the claim is fully or partially secured. Skip this section if the claim is entirely unsecured. (See DEFINITIONS, below.) State the type and the value of property that secures the claim, attach copies of lien documentation, and state annual interest rate and the amount past due on the claim as of the date of the bankruptcy filing.

5. **Amount of Claim Entitled to Priority Under 11 U.S.C. §§ 507(a).**
If any portion of your claim falls in one or more of the listed categories, check the appropriate box(es) and state the amount entitled to priority. (See DEFINITIONS, below.) A claim may be partly priority and partly non-priority. For example, in some of the categories, the law limits the amount entitled to priority.

6. **Credits:**
An authorized signature on this proof of claim serves as an acknowledgement that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

7. **Documents:**
Attach to this proof of claim form redacted copies documenting the existence of the debt and of any lien securing the debt. You may also attach a summary. You must also attach copies of documents that evidence perfection of any security interest. You may also attach a summary. FRBP 3001(c) and (d). Do not send original documents, as attachments may be destroyed after scanning.

Date and Signature:
The person filing this proof of claim must sign and date it. FRBP 9011. If the claim is filed electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what constitutes a signature. Print the name and title, if any, of the creditor or other person authorized to file this claim. State the filer's address and telephone number if it differs from the address given on the top of the form for purposes of receiving notices. Attach a complete copy of any power of attorney. Criminal penalties apply for making a false statement on a proof of claim.

DEFINITIONS

Debtor
A debtor is the person, corporation, or other entity that has filed a bankruptcy case.

Creditor
A creditor is the person, corporation, or other entity owed a debt by the debtor on the date of the bankruptcy filing.

Claim
A claim is the creditor's right to receive payment on a debt that was owed by the debtor on the date of the bankruptcy filing. See 11 U.S.C. § 101(5). A claim may be secured or unsecured.

Proof of Claim
A proof of claim form is a form used by the creditor to indicate the amount of the debt owed by the debtor on the date of the bankruptcy filing. The creditor must file the form with the clerk of the same bankruptcy court in which the bankruptcy case was filed.

Secured Claim Under 11 U.S.C. § 506(a)
A secured claim is one backed by a lien on property of the debtor. The claim is secured so long as the creditor has the right to be paid from the property prior to other creditors. The amount of the secured claim cannot exceed the value of the property. Any amount owed to the creditor in excess of the value of the property is an unsecured claim. Examples of liens on property include a mortgage on real estate or a security interest in a car.

A lien may be voluntarily granted by a debtor or may be obtained through a court proceeding. In some states, a court judgment is a lien. A claim also may be secured if the creditor owes the debtor money (has a right to setoff).

Unsecured Claim
An unsecured claim is one that does not meet the requirements of a secured claim. A claim may be partly unsecured if the amount of the claim exceeds the value of the property on which the creditor has a lien.

Claim Entitled to Priority Under 11 U.S.C. §§ 507(a)
Priority claims are certain categories of unsecured claims that are paid from the available money or property in a bankruptcy case before other unsecured claims.

Redacted
A document has been redacted when the person filing it has masked, edited out, or otherwise deleted, certain information. A creditor should redact and use only the last four digits of any social-security, individual's tax-identification, or financial-account number, all but the initials of a minor's name and only the year of any person's date of birth.

Evidence of Perfection
Evidence of perfection may include a mortgage, lien, certificate of title, financing statement, or other document showing that the lien has been filed or recorded.

INFORMATION

Acknowledgement of Filing a Claim
To receive acknowledgment of your filing, you may either enclose a stamped self-addressed envelope and a copy of this proof of claim or to view your filed proof of claim you may access the court's PACER system (www.pacer.psc.uscourts.gov) for a small fee to view your filed proof of claim.

Offers to Purchase a Claim
Certain entities are in the business of purchasing claims for an amount less than the face value of the claims. One or more of these entities may contact the creditor and offer to purchase the claim. Some of the written communications from these entities may easily be confused with official court documentation or communications from the debtor. These entities do not represent the bankruptcy court or the debtor. The creditor has no obligation to sell its claim. However, if the creditor decides to sell its claim, any transfer of such claim is subject to FRBP 3001(e), any applicable provisions of the Bankruptcy Code (11 U.S.C. § 101 *et seq.*), and any applicable orders of the bankruptcy court.

EXHIBIT **"A"**

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

---------- X

ANNA THOMAS,

Plaintiff(s),

-against-

CIRCUIT CITY STORES, INC. and "JOHN DOES", said names being fictitious and intended to represent employees of the defendant.

Defendant(s).

----------X

INDEX NO.: 20767/07

DATE FILED: 8/20/07

Plaintiff Designates
QUEENS COUNTY
as the place of trial.

The basis of venue is
Plaintiff's residence

SUMMONS

Plaintiff resides at
99-10 60th Ave., Apt. 5J
Corona, New York 11368

Queens County

To the above-named Defendant(s)

YOU ARE HEREBY SUMMONED to answer the Complaint in this action and to serve a copy of your Answer, or, if the Complaint is not served with this Summons, to serve a Notice of Appearance, on the Plaintiff(s) attorney(s) within 20 days after the service of this Summons, exclusive of the day of service (or within 30 days after the service is completed if this Summons is not personally delivered to you within the State of New York); and in case of your failure to appear or answer, judgment will be taken against you by default for the relief demanded in the Complaint.

Yours, etc.,

Dated: Jamaica, New York
August 8, 2007

By: Stuart Sears, Esq.
SHAEVITZ & SHAEVITZ, ESQS.
Attorney(s) for Plaintiff(s)
Office & P.O. Address
148-55 Hillside Avenue
Jamaica, New York 11435
(718) 291-3400

Defendant(s) Address(es):

CIRCUIT CITY STORES, INC.
c/o THE PRENTICE-HALL CORPORATION SYSTEM, INC.
80 State Street
Albany, New York 12207

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

----------X

ANNA THOMAS,

Plaintiff(s),

VERIFIED COMPLAINT

-against-

Index No.: 20767/07

CIRCUIT CITY STORES, INC. and "JOHN DOES", said names being fictitious and intended to represent employees of the defendant.

Defendant(s).

----------X

Plaintiff, by her attorneys **SHAEVITZ & SHAEVITZ, ESQS.,** as and for her Verified Complaint, respectfully complains of the defendants as follows, upon information and belief:

AS AND FOR A FIRST CAUSE OF ACTION
ON BEHALF OF PLAINTIFF ANNA THOMAS

1. That there is a general jurisdiction over the defendants under CPLR Section 301.

2. That at all times herein mentioned, plaintiff was and still is a resident of the County of Queens, State of New York.

3. That at all times hereinafter mentioned, the defendant, CIRCUIT CITY STORES, INC. is a domestic corporation duly authorized to do business in the State of New York.

4. That at all times hereinafter mentioned, the defendant, CIRCUIT CITY STORES, INC. is a limited liability corporation duly authorized to do business in the State of New York.

5. That at all times hereinafter mentioned, the defendant, CIRCUIT CITY STORES, INC. maintains offices to conduct business in the State of New York.

6. That at all times hereinafter mentioned, the defendant, CIRCUIT CITY STORES, INC. was the owner of a business operating as "CIRCUIT CITY" open to the general public at 9605 Queens Boulevard. Rego Park, New York.

7. That on or about December 28, 2006 at approximately 3:00 P.M., while lawfully and properly upon the premises known to the public as "CIRCUIT CITY" located at 9605 Queens Boulevard, Rego Park, in the County of Queens, and State of New York, the plaintiff was intentionally, negligently, recklessly, forcibly struck and assaulted, battered, knocked down and otherwise victimized which caused plaintiff to be in fear of imminent bodily injury and death, and which caused plaintiff to sustain serious, significant and permanent bodily injury, all occurring due to:

-the omissions of defendant, their agents, servants, and/or employees;

-defendants depraved, gross and reckless disregard for plaintiff's bodily safety and integrity;

-the negligent acts and/or omissions of defendant, CIRCUIT CITY STORES, INC., by and through their agents, servants, and/or employees, in the ownership, operation, management, supervision and control of it's business and the attendant performance of obligations thereat.

8. That on the above stated date, the defendant CIRCUIT CITY STORES, INC. , its agents, servants and/or employees owned the aforementioned premises.

9. That on the above stated date, the defendant CIRCUIT CITY STORES, INC. , its agents, servants and/or employees operated the aforementioned premises.

10. That on the above stated date, the defendant CIRCUIT CITY STORES, INC. , its agents, servants and/or employees maintained the aforementioned premises.

11. That on the above stated date, the defendant CIRCUIT CITY STORES, INC. , its agents, servants and/or employees managed the aforementioned premises.

12. That on the above stated date, the defendant CIRCUIT CITY STORES, INC. , its agents, servants and/or employees controlled the aforementioned premises.

13. That on the above stated location, defendant, CIRCUIT CITY STORES, INC., by and through their agents, servants and/or employees invited the general public, and more particularly the plaintiff to enter it's premises and otherwise patronize it's establishment.

14. That on the above stated location, defendant, CIRCUIT CITY STORES, INC.,hired security guards and security personnel to protect lawful customers and patrons.

15. That on the above stated date, the defendants, "JOHN DOES", were security personnel employed by defendant, CIRCUIT CITY STORES, INC.

16. That on the above stated date, the defendants, "JOHN DOES", names being fictitious and intending to represent the security personnel who intentionally, negligently, recklessly, forcibly struck and assaulted, battered and knocked down the plaintiff while acting within the scope of their employment.

17. That on the above stated location, defendant, CIRCUIT CITY STORES, INC., failed to employ an insufficient number of security guards and security personnel as a reasonable precautionary measure to prevent and/or reduce the likelihood of an assault occurring within it's premises amongst defendant's customers.

18. That on the above stated location, defendant, CIRCUIT CITY STORES, INC., their security guards and security personnel were negligent and/or reckless in not taking reasonable measures to prevent an assault on the herein plaintiff.

19. That on the above stated location, defendant, CIRCUIT CITY STORES, INC., their security guards and security personnel were negligent and/or reckless in causing to assault, batter and knock down the plaintiff.

20. That at all the times hereinafter mentioned, the defendant, CIRCUIT CITY STORES, INC., by and through their agents, servants and/or employees negligently hired and negligently kept in their employ members of their security guards and security personnel.

21. That at all the times heretofore and hereinafter mentioned, it was the duty and obligation of the defendants, their agents, servants, employees and/or licensees to operate and maintain the aforesaid premises, to properly train their employees and/or security guards, to permit actions and performances in a safe, proper manner so the aforesaid premises would not be dangerous to customers and lawful patrons.

22. That at all times hereinafter mentioned among the duties imposed by law upon the defendants herein, their agents, servants, employees, security guards and/or licensees, were to keep the aforesaid premises, free from dangers, to maintain and operate the same in a reasonably safe condition and manner for plaintiff and others lawfully thereat to shop and to keep same from conditions constituting a danger and menace to persons lawfully and properly shopping and/or traversing said premises.

23. That on the above stated date, while the plaintiff was lawfully on the aforesaid premises, plaintiff was caused to be injured through the improper and unlawful conduct of the defendants by reason of the negligence, carelessness and want of proper care of the defendants, their agents, servants, security guards and/or employees.

24. That the aforesaid occurrence and resulting injuries sustained by the plaintiff was caused wholly and solely through the carelessness, recklessness and negligence of the defendants herein, their agents, servants, security guards and/or employees or licensees, without any fault or lack of care on the part of the plaintiff contributing thereto.

25. That the said incident and resulting injuries to the plaintiff was caused through no fault of her own but were solely and wholly by reason of the negligence of the defendants, their agents, servants, security guards and/or employees in that the defendants failed to properly instruct the security guards in their performance of the duties required and demanded of them; in hiring untrained security guards; knowingly hiring, employing and retaining in its employ inexperienced, incompetent, careless, and reckless employees; all in violation of the laws, statutes, ordinances and regulations made and provided for the safe and proper operation, ownership, maintenance and control of said premises. Plaintiff further relies upon the doctrine of Res Ipsa Loquitur.

26. That by reason of the foregoing and by reason of the negligence, carelessness and recklessness of the defendants herein, their agents, servants, employees, security guards and/or licensees, as aforesaid, the plaintiff was caused to sustain serious, harmful and permanent injuries, has been and will be caused great bodily injuries and pain, shock, mental anguish; has and continues to experience the loss of normal pursuits and pleasures of life; has been informed and verily believes that she maybe permanently injured; has and will be prevented and/or limited in performing her usual duties; has incurred and will incur great expense for medical care and attention; in all to plaintiff's damage in the sum of that exceeds the jurisdictional amounts of any lower Court.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

----------X

ANNA THOMAS,

Plaintiff,

-against-

CIRCUIT CITY STORES, INC. and "JOHN DOES", said names being fictitious and intended to represent employees of the defendant,

Defendants.

----------X

DEMAND FOR A VERIFIED BILL OF PARTICULARS

Index No. 20767/07

PLEASE TAKE NOTICE that the answering defendant, CIRCUIT CITY STORES, INC., represented by RENDE, RYAN & DOWNES, LLP, the undersigned attorneys, requires that you serve upon said attorneys within thirty (30) days after service upon you of a copy of this demand, a verified bill of particulars, setting forth the following:

1. The date and time of the alleged occurrence.

2. With respect to the location where it is alleged the occurrence took place, state:

   a) The address of the premises in, at or near where the occurrence took place;

   b) The location where the occurrence took place as nearly as may be stated so as to permit identification and location from the building line or from another described fixed object;

   c) The location within the premises of any involved equipment, part or appurtenance (describe in adequate detail to permit ready identification and location).

3. Set forth a general statement of each and every act or omission which you will claim as the basis of the alleged assault and battery of the defendant.

4. If it is claimed that the answering defendant violated any law, ordinance, regulation, rule or statute, specify the title, chapter and section of the law, ordinance, regulation, rule or statute which it is alleged that the answering defendant violated.

5. Set forth each and every injury and/or condition allegedly sustained by each plaintiff as a result of the said occurrence indicating:

a) Its nature, extent, location and duration;

b) A complete description of any injury and/or condition claimed to be residual or permanent; and

c) The name and address of each physician, dentist, osteopath, chiropractor, nurse, physiotherapist or other medical practitioner treating or examining the plaintiff; the date of each visit; and, whether treatment has ceased or is continuing.

6. Give the length of time and specific dates it is claimed that each plaintiff was confined by reason of the alleged injuries:

a) To bed

b) To house, and

c) If treated at or confined to a hospital or other medical facility, state name and address thereof, and the dates of admission and discharge.

7. State with respect to plaintiff:

a) Plaintiff's place and date of birth and social security number.

b) Plaintiff's occupation at the time of the occurrence, with a description of plaintiff's duties.

c) The name and address of plaintiff's employer at the time of the alleged occurrence.

d) The daily or weekly earnings (gross and net) at the time of the occurrence.

e) If plaintiff was self-employed, set forth the business name and address of the plaintiff and the annual income (gross and net) of plaintiff from said business.

f) Whether the plaintiff was incapacitated from said employment; if so, the length of time including the specific dates that the plaintiff was allegedly incapacitated from attending to said employment.

8. Set forth the total amounts claimed to have been spent or incurred by or on behalf of plaintiff (setting forth the name of each provider of services along with the amount of the bill) for:

a) Hospital, clinic or other medical institutions' expenses

b) X-rays

b) Physicians' services

(1) Please itemize separately, given name and address of each physician.

d) Nurses' services

e) Medical supplies

f) Loss of earnings and the basis of computation thereof; and

g) Amount of nature (describe in detail) of any other special damages claimed.

9. If plaintiff received reimbursement or indemnification for any of the special damages set forth in response to item 10, or if payment of such bills or damages were made upon plaintiff's behalf, state:

a) The amount for which plaintiff was reimbursed or indemnified, or payment of which was made on plaintiff's behalf.

b) The services for which such amounts were reimbursed or indemnified, or for which payment was made on plaintiff's behalf.

c) The source or sources of such reimbursement, indemnification or payment. If payment was made by an insurance company, give the name, address and claim number.

10. Pursuant to Rule 3118 of the Civil Practice Law and Rules, demand is hereby made that you furnish the undersigned with a verified statement setting forth the post office address and residence of plaintiff indicating the street and number as well as the city and state.

PLEASE TAKE FURTHER NOTICE that in the event you have no knowledge of any or all of the above, same shall be so stated.

PLEASE TAKE FURTHER NOTICE that these are continuing demands and supplemental responses up to the time the case is placed on the trial calendar are required.

PLEASE TAKE FURTHER NOTICE that in the event of your failure to furnish such a bill of particulars within the said period of thirty (30) days, a motion will be made for an order precluding you from giving any evidence at the time of trial of the above items from which particulars have not been delivered in accordance with said demand.

Dated: White Plains, New York
September 26, 2007

Yours, etc.,

RENDE, RYAN & DOWNES, LLP.

By: _____
CHRISTOPHER J. WHITTON
Attorneys for Defendant
CIRCUIT CITY STORES, INC.
202 Mamaroneck Avenue
White Plains, New York 10601
(914) 681-0444

TO: SHAEVITZ & SHAEVITZ, ESQS.
Attorneys for Plaintiff
148-55 Hillside Avenue
Jamaica, New York 11435
Attention: Stuart Sears, Esq.
718-291-3400

EXHIBIT "C"

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

----------X

ANNA THOMAS,

Plaintiff(s),

NOTICE OF CERTIFICATION

-against-

Index No.: 20767/07

CIRCUIT CITY STORES, INC., and "JOHN DOES", said named being fictitious and is intended to represent the unknown employees of the defendant.

Defendant(s).

----------X

COUNSELORS:

The following papers accompany this Certification page:

NOTICE OF AVAILABILITY:

AUTHORIZATIONS:
-Elmhurst Hospital
-St. Luke's Roosevelt Hospital
-New York Othopedic Surgery and Rehabilitation
-Lenox Hill Radiology & Medical Imaging Associates, P.C.
-Sedgwick Claims Services (collateral source)

-PLAINTIFF'S VERIFIED BILL OF PARTICULARS;

-PLAINTIFF'S RESPONSE TO DEFENDANTS' COMBINED DEMANDS;

-PLAINTIFF'S DEMAND FOR VERIFIED BILL OF PARTICULARS;

-PLAINTIFF'S NOTICE FOR DISCOVERY & INSPECTION WITH DEMAND PURSUANT TO CPLR (d)(i)(1);

-NOTICE OF DEPOSITION UPON ORAL EXAMINATION.

Dated: Jamaica, New York
November 1, 2007

Yours, etc..

SHAEVITZ & SHAEVITZ, ESQS.
By: Stuart Sears, Esq.
148-55 Hillside Avenue
Jamaica, New York 11418
(718) 291-3400

TO: ***RENDE, RYAN & DOWNES, LLP***
Attorneys for Defendant(s)
CIRCUIT CITY STORES, INC.
202 Mamaroneck Avenue
White Plains, New York 10601
(914) 681-0444
File No.: S-125-CW

Form No.: 960

AUTHORIZATION AND RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

|This form has been approved by the New York State Department of Health|

Patient Name	Date of Birth	Social Security Number
ANNA THOMAS	05/26/37	053-46-3979

Patient Address
99-10 60th Avenue, Apt. 5J, Corona, New York 11368

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

Duplicate copies of all records provided pursuant to this authorization are to be provided to patient's attorney Shaevitz & Shaevitz, 148-55 Hillside Avenue, Jamaica, N.Y. 11435. If there will be a charge, please contact us at 718-291-3400.

7. Name and address of health provider or entity to release this information:
ELMHURST HOSPITAL, 79-01 Broadway, Elmhurst, New York

8. Name and address of person(s) or category of person to whom this information will be sent:
RENDE, RYAN & DOWNES, LLP, 202 Mamaroneck Avenue, White Plains, New York 10601

9(a). Specific information to be released:

☒ Medical Record from (insert date) 12/28/06 to (insert date) 12/28/06

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	12/08
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 11/20/07

Signature of patient or representative authorized by law.

MARK SHAEVITZ - Representative

STUART L. SEARS
NOTARY PUBLIC, State of New York
No. 02SE5064669
Qualified in Queens County
Commission Expires September 11, 2009

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

LIMITED POWER OF ATTORNEY

I, Anna Thomas
residing at 99-10 60th Avenue, Corona N-Y 11368

do hereby appoint my attorneys, SHAEVITZ & SHAEVITZ, ESQ. or their designated agents, employees or legal associates severally, as my attorneys-in-fact to act in my name place and stead, pursuant to Section 18 of the Public Health Law of the State of New York, in any way which I myself could do if I were personally present with respect to release of my medical records from any named health care provider or entity to whom a HIPAA authorization is presented in my name, which directs release of the records indicated on the HIPAA authorization to any third person, including any named category of person or entity; this power includes signing my name to such HIPAA authorizations for release of my health information. This power shall remain in effect until revoked.

This power of attorney shall not be affected by the subsequent disability or incompetence of the principal.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

In Witness Whereof, I have hereunto signed my named on this 31 day of May 2007

x Anna Thomas

State of New York
County of Queens

On this day of May 31 2007, before me personally came to me know, known to me to be the individual desribed in, and who executed the foregoing instrument and he acknowledged to me that he executed the same.

MARK A SHAEVITZ
Notary Public, State of New York
No 02SH5032300
Qualified in Nassau County
Commission Expires August 22 2010

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
ANNA THOMAS	05/26/37	053-46-3979

Patient Address: 99-10 60th Avenue, Apt. 5J, Corona, New York 11368

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

Duplicate copies of all records provided pursuant to this authorization are to be provided to patient's attorney Shaevitz & Shaevitz, 148-55 Hillside Avenue, Jamaica, N.Y. 11435. If there will be a charge, please contact us at 718-291-3400.

7. Name and address of health provider or entity to release this information:
ST. LUKE'S ROOSEVELT HOSPITAL, 1111 Amsterdam Avenue, New York New York 10025

8. Name and address of person(s) or category of person to whom this information will be sent:
RENDE, RYAN & DOWNES, LLP, 202 Mamaroneck Avenue, White Plains, New York 10601

9(a). Specific information to be released:

☒ Medical Record from (insert date) 12/29/06 to (insert date) 12/29/06

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	12/08
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 11/20/07

Signature of patient or representative authorized by law.

MARK SHAEVITZ - Representative

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

LIMITED POWER OF ATTORNEY

I, Anna Thomas
residing at 99-10 60th Avenue, Corona N-Y 11368

do hereby appoint my attorneys, SHAEVITZ & SHAEVITZ, ESQ. or their designated agents, employees or legal associates severally, as my attorneys-in-fact to act in my name place and stead, pursuant to Section 18 of the Public Health Law of the State of New York, in any way which I myself could do if I were personally present with respect to release of my medical records from any named health care provider or entity to whom a HIPAA authorization is presented in my name, which directs release of the records indicated on the HIPAA authorization to any third person, including any named category of person or entity; this power includes signing my name to such HIPAA authorizations for release of my health information. This power shall remain in effect until revoked.

This power of attorney shall not be affected by the subsequent disability or incompetence of the principal.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

In Witness Whereof, I have hereunto signed my named on this 31 day of May 2007

x Anna Thomas

State of New York
County of Queens

On this day of May 31 2007, before me personally came to me know, known to me to be the individual desribed in, and who executed the foregoing instrument and he acknowledged to me that he executed the same.

MARK A SHAEVITZ
Notary Public, State of New York
No 02SH5032300
Qualified in Nassau County
Commission Expires August 22 2010

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
ANNA THOMAS	05/26/37	053-46-3979

Patient Address

99-10 60th Avenue, Apt. 5J, Corona, New York 11368

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

Duplicate copies of all records provided pursuant to this authorization are to be provided to patient's attorney Shaevitz & Shaevitz, 148-55 Hillside Avenue, Jamaica, N.Y. 11435. If there will be a charge, please contact us at 718-291-3400.

7. Name and address of health provider or entity to release this information:

NEW YORK ORTHOPAEDIC SURGERY & REHABILITATION, 38-25 Astoria Blvd., Astoria, New York 11103

8. Name and address of person(s) or category of person to whom this information will be sent:

RENDE, RYAN & DOWNES, LLP, 202 Mamaroneck Avenue, White Plains, New York 10601

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

XX Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	12/08
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 11/20/07

Signature of patient or representative authorized by law.

MARK SHAEVITZ - Representative

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

LIMITED POWER OF ATTORNEY

I, Anna Thomas
residing at 99-10 60th Avenue, Corona N-Y 11368

do hereby appoint my attorneys, **SHAEVITZ & SHAEVITZ, ESQ.** or their designated agents, employees or legal associates severally, as my attorneys-in-fact to act in my name place and stead, pursuant to Section 18 of the Public Health Law of the State of New York, in any way which I myself could do if I were personally present with respect to release of my medical records from any named health care provider or entity to whom a HIPAA authorization is presented in my name, which directs release of the records indicated on the HIPAA authorization to any third person, including any named category of person or entity; this power includes signing my name to such HIPAA authorizations for release of my health information. This power shall remain in effect until revoked.

This power of attorney shall not be affected by the subsequent disability or incompetence of the principal.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

In Witness Whereof, I have hereunto signed my named on this 31 day of May 2007

x Anna Thomas

State of New York
County of Queens

On this day of May 31 2007, before me personally came to me know, known to me to be the individual desribed in, and who executed the foregoing instrument and he acknowledged to me that he executed the same.

MARK A SHAEVITZ
Notary Public, State of New York
No 02SH5032300
Qualified in Nassau County
Commission Expires August 22 2010

OCA Official Form No.: 960

AUTHORIZATION AND RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
ANNA THOMAS	05/26/37	053-46-3979

Patient Address

99-10 60th Avenue, Apt. 5J, Corona, New York 11368

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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).** Duplicate copies of all records provided pursuant to this authorization are to be provided to patient's attorney Shaevitz & Shaevitz, 148-55 Hillside Avenue, Jamaica, N.Y. 11435. If there will be a charge, please contact us at 718-291-3400.

7. Name and address of health provider or entity to release this information:
LENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOC., 61 East 77th Street, New York, New York 10021

8. Name and address of person(s) or category of person to whom this information will be sent:
RENDE, RYAN & DOWNES, LLP, 202 Mamaroneck Avenue, White Plains, New York 10601

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☒ Other: MRI films and reports

Include: (*Indicate by Initialing*)

_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	12/08
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: 11/20/07

Signature of patient or representative authorized by law.

MARK SHAEVITZ - Representative

STUART L. SEARS
NOTARY PUBLIC, State of New York
No. 02SE5049200
Qualified in Queens County
Commission Expires September 11, 09

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